**Department of Veterans Affairs** **VHA DIRECTIVE 2000-016**
**Veterans Health Administration**
**Washington, DC 20420** **June 5, 2000**

# MEDICAL REHABILITATION OUTCOMES FOR STROKE, TRAUMATIC BRAIN INJURY, AND LOWER-EXTREMITY AMPUTEE PATIENTS

**1. PURPOSE.** This Veterans Health Administration (VHA) Directive provides Department-wide policy regarding the recording and tracking of medical rehabilitation outcomes for stroke and the special patient populations of traumatic brain injury (TBI) and lower-extremity amputations.

## 2. BACKGROUND

a. Public Law (Pub. L.) 104-262, Section 104, The Eligibility Reform Act, established the requirement that VHA maintain its capacity to provide for the specialized treatment and rehabilitative needs of selected patient populations including amputations and TBI. During the first 2 years, the two major capacity categories addressed by the Department for these two impairment groups were resources as measured by dollars, and reasonable access as measured by timeliness. Beginning in Fiscal Year (FY) 99, VHA was challenged with implementing indicators of workload and outcomes (functional and quality) in lieu of resources as its measures of capacity for these special emphasis populations.

b. In FY 99, the Patient Treatment File (PTF) indicated a total of 12,542 patients were treated with either a principal diagnosis of stroke or a principal stroke diagnosis associated with a secondary diagnosis. Medical rehabilitation outcomes were reported on only 1,412, which represent those patients who were treated in a rehabilitation bed setting. This represents only 11 percent of the acute stroke patients admitted to the Department of Veterans Affairs (VA) health care system. The Uniform Data System for Medical Rehabilitation (UDSMR) reports that stroke patients comprise approximately 30 percent of the admissions to rehabilitation beds, both in VHA and the private sector. Little attention has been given to tracking and reporting outcomes on those patients treated outside the traditional rehabilitation bed setting. Stroke and TBI patients are both classified as Special Care under the Veterans Equitable Resource Allocations (VERA) model.

c. The Physical Medicine and Rehabilitation (PM&R) Program Office (117C) has been tracking medical rehabilitation outcomes of all patients discharged from inpatient medical rehabilitation bed units under a national contract with UDSMR since 1993. Today, PM&R has the capability of tracking rehabilitation outcomes across the full continuum of care through the Functional Status and Outcomes Database (FSOD) for Rehabilitation located at the Austin Automation Center (AAC). FSOD was established in FY 97, through a cooperative effort between the PM&R Program Office, AAC, and UDSMR. FSOD utilizes Department of Veterans Affairs (VA) Functional Independence Measure (FIM) software (also referred to as FIMware) for data entry. Information regarding rehabilitation outcomes on the PM&R bed units is transferred electronically to the UDSMR each quarter for preparation of individual facility reports including comparison of data to the private sector. Since incorporation of FSOD at the AAC, outcomes data may now be tracked on any selected impairment group without regard to the bed unit or setting in which rehabilitative care is provided. FSOD provides the flexibility for

tracking rehabilitation outcomes across the full continuum of care for the stroke, amputee, and TBI populations. It is also a resource from which data will be extracted to measure the Department's performance in meeting its capacity and other monitors for the two select special emphasis impairments.

d. In May 1998, enhancements were added to FSOD allowing the tracking of patient satisfaction items specific to the patient's rehabilitation experience and continued use of lower-extremity prosthesis at specific intervals following prevision of the prosthetic limb. Addition of these enhancements followed input from the Advisory Committee on Prosthetics and Special Disabilities Program (ACP&SDP) and the Veterans Affairs Committee on Rehabilitation (VACOR).

**3. POLICY:** It is VHA policy that effective October 1, 2000, all VA medical centers will have achieved connectivity to the Functional Status and Outcomes Database for Rehabilitation at the AAC. Effective January 1, 2001, FSOD will be utilized at all VA medical centers to measure and track the rehabilitation outcomes on all new stroke, lower-extremity amputees, and TBI patients.

**4. ACTION**

a. Each of the 23 designated TBI network of care facilities and each medical center with an amputee clinic team or Preservation Amputation Care and Treatment (PACT) Coordinator will be responsible for utilizing FSOD to enter and track rehabilitation outcomes of their respective TBI and amputee patients across the full continuum of their care.

b. All VA medical centers will be responsible for tracking functional outcomes on all new stroke patients receiving rehabilitation services utilizing the FSOD.

c. Connectivity to FSOD at AAC and download of VA FIM will be coordinated by the local Information Resources Management Office and the VA FIM Help Desk at Austin. ***NOTE:*** *The AAC Help Desk telephone number is (512) 326-6780.*

d. A level of access to FSOD will be assigned by the PM&R Program Office in cooperation with AAC staff. Requests for access should be directed to the PM&R Office by calling (901) 544-0199.

e. Facilities should request credentialing in administration of the FIM assessment tool directly to UDSMR in Buffalo, NY. ***NOTE:*** *The UDSMR telephone number is (716) 829-2076.* Under the VHA national contract with UDSMR, each facility without a designated rehabilitation bed unit may request two clinicians to be credentialed in administration of the FIM at no charge. Results of the credentialing examination are forwarded to the PM&R Program Office, which manages the UDSMR contract. ***NOTE:*** *Facilities desiring to have additional staff credentialed in administering the FIM will be charged a rate per examination as established by the national contract, which is currently $35 per person.*

f. One person will be designated locally to coordinate administration of the FIM, data entry into the FSOD, and management of the facility's data. The designee will be the primary liaison

to the PM&R Program Office for monitoring and tracking outcomes. ***NOTE:*** *It is recommended that the designee be a rehabilitation manager, clinician, TBI case manager, PACT coordinator, or quality management person actively involved in rehabilitation care management.*

g. Training in local use and management of FSOD will be the responsibility of the PM&R Program Office in cooperation with the Employee Educational System.

h. Validation of the data and reporting of the performance measurement results will be the responsibility of the PM&R Program Office in cooperation with the Offices of Performance and Quality Service (10Q) and Policy and Planning (105).

**5. REFERENCES:** None.

**6. RESPONSIBILITY:** The Director, Physical Medicine and Rehabilitation, Rehabilitation Strategic Health Group (117C), is responsible for contents of this directive.

**7. RESCISSION:** This VHA Directive expires June 30, 2005.

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Acting Under Secretary for Health

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